

THE MEDICAL EXAMINER,

And Retrospect of the Medical Sciences.

Vol. VI.]

PHILADELPHIA, SATURDAY, DECEMBER 23, 1843.

[No. 25.]

CLINICAL LECTURES AND REPORTS.

JEFFERSON MEDICAL COLLEGE.

CLINIC OF PROFESSOR MÜTTER.

(Reported by H. T. Child.*)

CASE I.

TUMOUR OF THE NAPE OF THE NECK.

November 28th, 1843.—Professor Pancoast introduced a female patient with a tumour on the nape of the neck, of thirteen years standing, which he proceeded to remove by carefully dissecting out the whole sac. It was an encysted, steatomatous tumour, about one and a half inches in diameter. A small artery required a ligature, and the parts were then drawn together by means of adhesive straps, and a light dressing applied over the whole.



Microscopic examination.—The contents of this tumour contain numerous beautiful rhomboidal crystals, most of which are very regular, and all seem perfectly defined. Whether other tumours of this kind contain these crystals I have not yet had means of ascertaining: if so, this is a fact which appears to have been overlooked by previous observers. The

form of the crystals is seen in the figure, which represents the field of the microscope under a magnifying power of about 600 diameters. The crystals are lamellar, and very thin, not exceeding in thickness the thirty thousandth of an inch. They seem not to be soluble in water, slowly soluble in alcohol, and are readily dissolved in oil of turpentine. They remain unchanged, floating in nitric or muriatic acid diluted with an equal quantity of water, and are equally unaffected by a strong solution of caustic potash, which dissolves all but the crystals.

Professor Mütter then introduced

CASE II.

CONGENITAL ICTHYOSIS.

M. A—, a female, aged 10 years. Lymphatic temperament; general health good.

This child you may recollect, gentlemen, has already been presented at the clinic; but I bring her before you to-day in order to exhibit the happy influence of the treatment prescribed. The skin, you observe, is becoming pale and smooth; the scabs, which covered her literally from head to foot, are falling off, leaving a smooth and healthy surface, where before there was nothing but a loathsome and fetid ulcer. Her cheeks are becoming rosy, her tongue clean, her appetite excellent, and her excretions regular. Her hands and feet,* although distorted, look a little more natural, and the joints are more flexible.

The remedies, from the employment of which so much benefit has been derived, are general mucilaginous baths every other day, weak sulphate of copper washes to the ulcers, (gr. j. to ʒij. of water,) a good diet, warm clothing, fresh air, and, above all, the internal use of "*Donovan's Solution*," the Liquor Hydriodatis Arsenici et Hydrargyri. I cannot too strongly recommend this article in certain forms of cutaneous disease; those, for instance, in which a steady and protracted alterative course is required, and where the stomach is too irritable to bear either iodine, arsenic, or mercury, in their usual forms of administration. You have seen its good effects in the cases of lupus and some other diseases; but in none has its beneficial influence been so marked as in the case before us. We shall continue the treatment. We began with three drops three times a day, and have gradually increased, till at present she takes nine drops three times a day.

CASE III.

ORIGINALLY A CASE OF LUPUS OF THE LOWER LID,

For which an operation was performed last winter. See Medical Examiner for Feb. 14, 1843, No. 2, Vol. vi.

* The fingers and toes of this child are webbed; and the adhesions so close and perfect, that in the feet and left hand especially it is almost impossible to distinguish the natural lines of separation for the toes and fingers.

*The regular reports commence with this lecture. Since Professor Mütter's service commenced on the 4th of October, he has operated for cataract—removed a glandular tumour—performed two operations for hare-lip, with fissure of the hard and soft palates in infants—an extensive plastic operation for contraction of the fingers and thumb—extirpated two tonsils—operated for fistula lacrymalis—catheterised the Eustachian tube, &c. Professor Pancoast has also introduced from his private practice a number of patients, in order that the class might have an opportunity of witnessing the operations. Of these, there was a case of amputation of the left mamma—an operation for cancer of the lip—and a case of paracentesis cerebri.

Many of you, I have no doubt, recollect Mrs. T—, upon whom, during the last season, I performed a most extensive *Blepheroplastic* operation for the cure of an obstinate *noli me tangere*. The operation has proved, as you perceive, eminently successful; not a vestige of the disease, from which she had suffered severely for seven years, now remains: and it is really almost impossible, without a minute examination, to say upon which eye it was performed. This case is highly interesting, strongly substantiating, as it does, the views entertained by Martinet de la Creuse, Deiffenbach, Phillips and others, in relation to the influence of the application of healthy tissue to a part from which cancerous formations have been previously removed.

In this and many other cases, I have unquestionably accomplished a cure by performing a plastic operation at the time the diseased tissue was removed, instead of allowing the parts to heal by granulation.

I do not pretend to explain the fact, *causa latet vis est notissima*; but certain I am, that no better advice can be given you than this: *endeavour, whenever you operate for cancerous or malignant disease, to cover in the surface from which you remove it with healthy skin*; and rest assured that, by so doing, you will very much diminish the chances of a reappearance of the affection.

CASE IV.

ORIGINALLY A CASE OF CANCER OF THE LIP.

Here is another highly interesting case, and one that fully bears me out in what I have just been telling you. Wm. L—, some of you will recollect, submitted during the last winter to a very serious and extensive *Cheiloplastic* operation, for the removal of cancer of the lower lip, involving the whole organ. This diagram explains to you the operation I performed; and although no single operation will answer in every case, yet where this can be performed, I vastly prefer it to any other method. It consists in first removing the diseased tissue by a semilunar incision, carried below it and down to the bone. Then, in order to obtain a proper flap for the lip, carrying a perpendicular incision directly through the centre of the chin, and as far down the neck as may be necessary; next commencing at the terminal extremity of this incision, carry another, curvilinear in shape, parallel with that made for the removal of the tumour, along the base of the jaw or lower, as the case may be, until it reaches a point opposite the commissure of the mouth. This accomplished, dissect up the flap included between the two incisions, and then perform a similar operation on the opposite side. The two flaps being thus prepared, are to be lifted up into the position originally occupied by the lip, and united to each other at the mesial line by the twisted suture. This operation, gentlemen, I believe belongs to me; for I performed it as long since as 1834. Mr. Buchanan, of Glasgow, has recently published a paper upon this subject, and supposes the method to have originated with himself; but, as I have just told you, I performed a similar operation several years since. The operation of Dupuytren, which consists in simply removing the diseased mass by a curvilinear incision, and then trusting to granulations to fill up the cavity, is rarely successful, and the disease, so far as my experience goes, is more apt to return than when plastic surgery is had recourse to.

Nor is the operation in which a flap is detached from the chin and throat by a single perpendicular

incision on each side, and then forcibly dragged upwards and retained in its place by ligatures, more to be relied on. A few successful cases, among them that of Mr. Earle, published in the 12th volume of the *Medico-Chirurgical Transactions*, are to be met with, but they are not sufficiently numerous to induce us to prefer the operation to that just described.

Of course, the simple V incision can only be practised when the tumour is small; but where the extent of the disease does not contraindicate its employment, it will answer an excellent purpose.

CASE V.

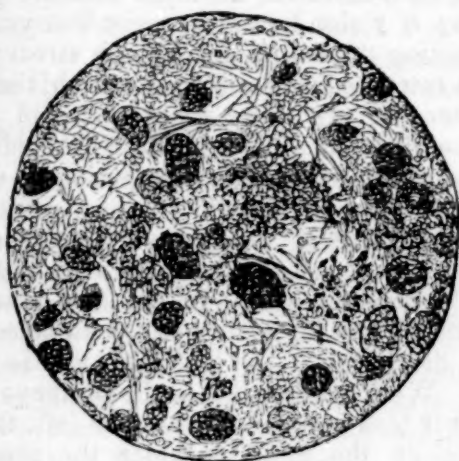
CEPHALOMATOUS TUMOUR.

A. L—, æt. 50 years, has a cephalomatous tumour of the lower lid, involving the entire organ, and projecting into the orbit at the inner canthus. In size, externally, it equalled a hen's egg, was livid in colour, with here and there an ulcerous spot of a lighter hue, and presented the consistence of the medullary tissue of a healthy brain. Its attachments were confined to the inner canthus—all the other portions of the tumour being moveable. The general health of the patient is excellent, and the lymphatics in the vicinity not at all enlarged or diseased. There is some shooting pain in the tumour, and it increases rapidly in size. The success attending the employment of plastic surgery in similar cases, induced Professor Mutter to perform the following operation, which differs in some respects from that employed in the case of Mrs. T— and others.

The hair having been previously shaved from the temple and cheek, the patient was seated with his head resting against the chest of an assistant, and the operation commenced by carrying an oblique incision from the outer canthus down to the centre of the cheek; another was then made from the inner canthus to the terminal extremity of the first. The tumour was thus included between the two, and then immediately dissected out as completely as possible, leaving a space of the shape of the letter V. After its removal, the disease was found to extend deep into the orbit, and also to involve a portion of the upper lid. To get rid of this, the diseased portion of the lid was at once cut away, and then the base of the tumour seized with a pair of double hooked forceps, brought forward as much as possible, and carefully separated with the scalpel from all its attachments. This part of the operation was very painful, as the tumour adhered closely to the ball of the eye, which it had displaced from its natural position. After the removal of the diseased mass, both the ball of the eye and the adjacent bones of the orbit were found perfectly healthy. The patient was allowed to rest a few minutes, and the bleeding having in a great measure ceased, the next step of the operation was commenced. Starting from the superior extremity of the first incision at the external canthus, the scalpel was carried upwards about an inch above the orbit, and towards the temple, then turned back, so as to mark out a circular flap about three quarters of an inch in length, from the base of which it was carried outwards, in a *curvilinear* direction, for about an inch and a quarter, in order that this margin might correspond with the natural curve of the eyelid. From the terminal extremity of this, another incision was carried downwards and forwards until it reached a point opposite the union of the two first. The flap included in these incisions was then dissected up, brought over the raw surface from which the diseased tissue had

been removed, and attached to the skin along the nose by several stitches of the interrupted suture; the round portion at the upper margin fitting accurately the space left in the upper lid by the removal of its diseased tissue. The surface from which the flap had been removed was then partly closed by sutures, and the other portions left to heal by granulations, and dressed with water dressing. The treatment ordered consisted in the application of *cool water to the flap*, maintaining the head in an elevated position, and placing the patient upon the antiphlogistic system.

Professor M. observed that there were many other operations proposed for the restoration of the eyelids, most of which would be found either described or referred to in the report of his lecture on Blepharoplasty operations, published in the Medical Examiner for February 14, 1843, No. 2, Vol. vi.



Microscopic Examination of the Tumour.—The accompanying drawing represents a thin slice of the medullary part of the tumour magnified about 600 diameters. In this were seen no bloodvessels, and very few fibres of cellular tissue. The hematoid portion contained many globules like those seen in the figure, within which are nuclei or granules; and besides numerous bloodvessels, this reticulated tissue was supplied with many tubes, larger than the minute bloodvessels, which tubes terminated in a bulbous extremity filled with blood globules. Some of the drawings of Müller compare quite well with the above.

[NOTE.—The examination of the tumors was made by Mr. Southwick, a member of the class, who, with a laudable zeal, is devoting much time to microscopic investigations.—T. D. M.]

PROFESSOR PANCOAST CASE OF PARACENTESIS CEREBRI,

At the Clinic of Jefferson Medical College, November 15th, 1843.

(Reported by H. T. Child.)

Prof. Pancoast introduced before the class a child, æt. 7 months, with enormous enlargement of the head, the consequence of chronichy drocephalus. This child, the lecturer observed, is of German descent, and I am informed was active and lively at birth, but, unusually dark coloured, the blueness gradually diminishing so as to disappear altogether by the fourth or fifth day. At the end of five weeks the child was seized with convulsions without apparent cause, which recurred

at intervals of a few minutes for several days. The case was judiciously managed by Dr. Bournonville of this city. The child recovered so as to be able to take its nourishment well and seemed to thrive; some permanent affection of the brain soon after began to manifest itself, by occasional squinting, and an almost constant rolling motion of the head, which began gradually to increase in size. The first sign of the increase of the head, was apparent at the anterior fontanelle, which was enlarged by recession outwards and backwards of the parietal bones, and gave upon pressure a sense of fluctuation. It is about two weeks since I first saw the patient; the head then measured twenty-one inches around above the ears, nineteen and a half from the forehead to the nape of the neck. The anterior fontanelle was enormously enlarged and of a lozenge shape, running from before backwards along the sagittal suture, from the frontal to the occipital bone, a distance of seven and a half inches, and from side to side along the coronal suture seven inches. The sutures at the anterior side of the squamous portion of the temporal bones, were also partly opened; all the others were unusually firmly ossified, in consequence apparently of the bones being pressed together at the posterior and lower part of the cranium, by the distension which had opened the fontanelle. The child squinted constantly with the left eye, and was distorted on the right side of the back by the contraction of the spinal muscles. I tapped the brain with a small gold trochar, in the presence of several medical gentlemen, and removed a gill of transparent fluid which was saline to the taste, and on being analyzed by Mr. Frederick L. Johns, of this city, was found to contain in

1000 parts	4 parts of carbonate of soda.
Specific Gravity 1.035	13 " of muriate of soda.
	3 " animal mucilage and extractive matter.
	886 " water.

The child, a few moments before, had been in convulsions; it seemed relieved by the operation and took the breast immediately. The flap sunk down after the operation so as to bring out the bony edges of the fontanelle in relief, but the bones of the cranium were too firmly ossified toward the base to be made to approach each other, presenting as it appears to me an almost insurmountable obstacle in the way of cure. The flap of the scalp has again raised, as you observe, by a reaccumulation of the fluid within, though the head is found to be diminished nearly an inch in circumference.

Tapping offers the only prospect of relief in these cases, and that I believe is slight. The parents are apprised of this, and are even prepared for a fatal result, in case it should follow the evacuation of the fluid. I do not, however, believe it likely to happen, and I intend to guard against it as much as possible by taking away but a moderate quantity of fluid at one time, and repeating the operation from time to time, rather than take away at once the great amount that must necessarily be collected to have formed this great expansion of the cranium.

This operation has been performed many times: by Messrs. Conquest, Russel and Butcher of Great Britain, Graefe of Germany, and Malgaigne, of Paris, and several times in this country. According to Mr. Conquest's statement he has been successful in curing ten cases out of nineteen. There has been some difference of opinion as to the most appropriate place for the puncture. Mr. Conquest preferring the track of the frontal suture. Mr. Russel, one of the sides of the fontanelle. I have selected the middle part of

the lateral wing of the fontanelle, as the point most likely to reach the cavity of the lateral ventricle, and avoid the track of the middle artery of the dura mater, and will operate on the right side as this is the most prominent. The trochar must pass through the scalp, the three membranes of the brain, and through the thinned and expanded portion of the brain above the ventricles. The fluid must have collected in the ventricles; and expanded the brain, so as to have unfolded the convolutions, breaking down the partition between the ventricles.

The trochar was then inserted without any manifestation of uneasiness on the part of the child, and about three ounces and a half of fluid removed; the flap of skin sunk down, as in the former operation. Before removing the trochar a plug was inserted in the orifice, lest the suction made in withdrawing it should draw some air into the cavity of the ventricle.

The child gaped and seemed like a person just wakening from a deep sleep.

ABSTRACT OF TWO CLINICAL LECTURES,

Delivered at the Dispensary of the Medical Department of the Columbian College, Washington, D. C.

BY WILLIAM P. JOHNSTON, M. D.

Professor of Surgery.

Reported for the Medical Examiner.

AMAUROSIS.

November 14th, 1843.—Dr. J. commenced by saying that as amaurosis had been the subject of a recent clinic, he would not again describe the varieties of this disease with the treatment most appropriate to each particular form; he proposed on the present occasion to notice some of the peculiarities of the case before us, and to contrast the symptoms of this patient with those of the female, who presented herself at the clinic of last week. In examining the eyes of this patient the first thing that strikes our attention is the unnatural dilatation of both pupils, especially the left, and their inability to contract even when exposed to a bright light. Pursuing the examination a little further, you will remark within the pupil of the right eye, and apparently at the very bottom of this organ, a yellowish concave opacity or discolouration. In the left eye, a similar opacity is seen, more limited however in extent, for around it we recognise the natural black colour. Before examining into the history of the case, let us see whether we can arrive at a diagnosis by the aid alone of the data furnished us by the inspection of the eye. Can this be a case of cataract? Certainly not; for in the first place the opacity is deep within the cavity of the eye, and far beyond the lens. Let us now examine the eyes with a lighted candle, after the method of Sanson. I can now recognise distinctly, as in an healthy eye, the three images of the candle. The first, distinct and well defined, reflected by the cornea; the second more diffused, reflected by the anterior capsule of the lens; the third presents a well defined margin, but is an inverted image, owing to the posterior capsule of the lens being concave, and moves in a direction opposed to that of the other two, and of the light itself, as it is alternately elevated and depressed. It is now certain that the opacity is not in the lens, otherwise we should no longer recognise the second and third images, at least as distinctly as we have done in this case. As this is not a case of cataract,

we think it must be one of amaurosis, from some organic lesion of the retina. Let us see if the history of the patient will support us in this opinion. We are told by the patient that he has been going blind for about two years; formerly he was much annoyed by seeing, as he says, "stars," or bright specks, which appeared to float before his eyes. These are now no longer visible, but his sight has become still more impaired; objects are now imperfectly seen, they are ill defined and confused. We have now sufficient to warrant a positive diagnosis; permanently dilated pupils; a concave opacity at the bottom of the eye; abolition of sight almost complete, succeeding to altered or deranged function of the organ, during which strange and unnatural objects were perceived. There is something very striking in the exterior appearance of an amaurotic patient. I noticed it in the man before us, and it first awakened my suspicions as to the nature of his case. He walks with his head elevated, his eyes steadily gazing before him; if vision be not entirely lost you will see him selecting the sunny side of the street or turning his eyes towards the point from which the brightest light proceeds. In these cases of torpid amaurosis the retina becomes more and more insensible as the sight declines until at last the patient is enabled to gaze at the sun with impunity.

There are one or two circumstances connected with the present state of this patient to which I must now call your attention. In the first place he has told us that when he wishes to see an object he does not look directly at it, but laterally; this is easily explained. We have seen that in the right eye, in which the sight is less impaired than in the left, the opacity seen through the pupil occupies the centre, while around we perceive the normal black colour. Now if the patient looks directly at an object, the image must impinge upon the centre of the retina, or upon the part most diseased; whereas, if he regards it obliquely, the image falls to one side, or upon a portion of the retina which is less affected. In a similar manner we must account for another peculiarity in this case. We mentioned that in torpid or organic amaurosis, the patient discerns the light better at mid-day, or in a very bright light; the patient before us, on the contrary, has said that he sees better towards dark. This is not owing to photophobia, produced by irritation or inflammation of the retina, because none such exists; but rather to the fact that towards dusk the pupil of the right eye, which at this time you find more contracted than the opposite one, will dilate to a moderate extent and allow the image of an object to be reflected more readily upon some portion of the retina beyond the opacity. The retina is not always affected throughout its whole extent in amaurosis, as the present case shows; sometimes a single point is diseased and the patient sees a black spot always before his eyes. The function of vision may become deranged in various ways; sometimes the patient sees double; a bright light or halo may surround an object; sparks or flashes of light may be seen, or spots may be constantly floating before the eyes (*muscæ volitantes*); objects may appear disfigured, or only a portion of the same may be seen. A young lady of nervous temperament whom I attended about a year since, had been suffering for some days with a dull headache, when suddenly, while intently occupied in some worsted work, she raised her eyes declaring that she could see only the superior half of whatever she gazed at. This partial amaurosis soon subsided; violent headache, morbid acuteness of hearing, and a strong bounding pulse followed; it was some days before these symptoms subsided.

To return: the examination that we have made of our patient, has led us to the conclusion that this case is one of amaurotic ambliopia, which has already nearly terminated in torpid amaurosis, the result of some organic lesion of the retina.

Prognosis most unfavourable; the patient has already been under the hands of physicians, both in Virginia and in Philadelphia, and finds himself in no way benefited. Sooner or later the imperfect vision which is left to him will be entirely lost.

Before dismissing this case let me again remind you of the one we saw last week. This latter was an example of irritable amaurosis, complicated as it often is, with congestion of the retina. I allude to this case that you may contrast the pupils of the patient before us with those of the former. In this man the pupils are permanently dilated but perfectly round. In the female that we saw last week the pupil of the affected eye was contracted and of an irregular shape; the irritation had besides extended from the eye to the lids, and hence the constant batting of the lids to which I called your attention.

LENTICULAR CATARACT, (HARD.)

November 17th.—Betsey Butler, æt. 75 years, of good constitution, has enjoyed an unusual share of health. About four years since she first began to notice that her sight was becoming impaired; objects appeared to her less distinct than natural, and as if covered by a veil. She has never received any injury about the head, nor has she suffered from pain in the eyes or head. She long since remarked that she could see more distinctly towards evening, or when her back was turned to the light; in the day, or when gazing at a bright light, she could see but little. Her sight has continued to diminish little by little; about a year since she ceased to see by the left eye. At this moment she is still enabled to see somewhat with the right eye, sufficiently to recognise objects held before her.

If we examine the right eye we shall find that the iris appears healthy, it dilates and contracts readily, it is free from every anormal adhesion, and the pupil is perfectly round. If we look through the pupil, we find at a short distance behind, a yellowish green opacity of a dull colour; around the margin of this opacity we perceive a black rim, being the shadow cast by the iris upon the opaque lens, (this may also in part be due to the uvea which forms the edge of the pupil.) The left eye presented a similar appearance, except that the opacity was more marked. We performed the operation of couching upon this eye about a month since, we shall see with what success.

How are we to know that this case is one of cataract, and not some other affection? It would be impossible to confound this case with any but glaucoma or amaurosis. In glaucoma the opacity offers some shade of green; thus far there is a resemblance between this disease and the one before us, in which, as we have said, the opacity is of a yellowish green. But in glaucoma the opacity is deep within the eye, it is concave and cannot be seen when the eye is viewed laterally; the contrary we have seen obtains in the patient before us. Again, in hard lenticular cataract, of which this is an example, the shadow cast by the iris upon the opacity behind, is a valuable sign which is never seen in glaucoma.

Cataract can never be mistaken for confirmed amaurosis. In the latter disease the pupils are widely and permanently dilated and vision is either entirely abolished or the sensibility of the retina can only be awakened by the brightest light. In cataract, on the contrary, the pupil dilates and contracts

readily, and as the opaque lens offers a mechanical obstruction to the passage of the rays of light, the patient is compelled to seek obscurity, to shade his eyes or turn his back towards the window in order that the pupil may dilate, and the rays of light then be admitted through portions of the lens most distant from the centre; the opacity in these cases of hard lenticular cataract being most marked in the centre, and diminishing from this point to the circumference.

We have still another method of distinguishing cataract from both glaucoma and amaurosis; we allude to the signs furnished by the catoptric method of examination. At our last lecture, we noticed that when a light was held to the eye of the patient with confirmed amaurosis, the three images of the candle were seen as distinctly as in an healthy eye. In lenticular cataract, on the contrary, the third or inverted image reflected by the posterior capsule, loses its distinctness at the commencement of the opacity, and when the cataract becomes fully formed or matured this image is no longer to be seen. The second erect image becomes also indistinct. In the right eye of the patient, whose case we are now considering, you will see on close examination that the second and third images of the candle are barely perceptible, if at all. We have now satisfactorily shown that our patient is affected with lenticular cataract; this cataract is moreover of firm consistence, which is indicated by its dark colour, and the distance at which it is seen from the pupil, increasing the dimensions of the posterior chamber, the latter being the result of the contraction of the lens, and finally by the opacity being more complete in the centre than towards the circumference.

When we first saw this case we at once decided upon the propriety of an operation. The patient had lost the sight of one eye entirely, and that of the other was much impaired. By dilating the pupil of the eye in which the cataract was completely matured, we found that she could then recognise objects around her; it was clear therefore that the case was not complicated with amaurosis. The patient was advanced in years, (75,) but age alone does not constitute a contra-indication to the operation. Her constitution was good, her general health perfect; besides this she was of a spare habit of body, all of which was in her favour. The operation of couching was performed about a month since; we were careful in the operation, to avoid carrying the lens so low as to press upon the retina, by which we might have produced incurable amaurosis. The patient suffered but little during the operation, a most favourable sign, as very acute inflammation never follows under such circumstances. There was no after treatment instituted except the administration of a few drops of laudanum and low diet. The eye was examined daily after the second day; no local inflammation supervened, but slight pain was felt in the eye, and there was no constitutional reaction. The cure has been perfect; the patient can now readily recognise the hands of a watch; with the aid of a suitable pair of glasses, her sight will still improve.

You remark that only one eye was operated upon; the reason for this was that the patient could still see by the other eye, and as there is always more or less risk attending the operation, it was more prudent not to endanger the eye which was still useful to her. In time the cataract of the right eye will also become mature, and should any accident happen to the eye, upon which we have already operated, it will then be time enough to remove the lens from behind the pupil of the other.

The operation of extraction is equally applicable

to cases of hard cataract; couching, however, can be performed with greater facility, and it has also this great advantage over the former, that it may be repeated a second or even a third time if necessary. When the eye is deep within the socket, which is the case with this patient, couching should always be preferred; this latter operation has also been recommended in very aged persons who have the "arcus senilis" well marked.

Washington, Nov. 20th, 1843.

PHILADELPHIA HOSPITAL.

(Service of MEREDITH CLYMER, M. D.)

Reported by George N. Burwell, M.D., Resident Physician.

CASE I.

PNEUMONIA—BRONCHITIS—DIARRHŒA—PREGNANCY—RECOVERY.

Elizabeth R.—aged 27, married, entered the hospital the evening of August 5th. She stated that about a week before, she was taken with a chill after exposure, which was succeeded by a fever and general pain, and considerable dyspnœa; was bled two days after the chill with benefit.

We found her with great heat of skin; profuse perspiration, standing in drops on her forehead; tongue coated with a brownish fur in the middle; red at the edges; pulse 120. full; respiration 34, high and confined to the right side of the chest; cough suppressed; no expectoration; face flushed; dilatation of nostrils. Percussion anteriorly clear, except in the precordial and axillary regions of the left side; posteriorly clear except the upper portion of the left side, and where pain is felt on percussion. Respiration anteriorly clear, except in the axillary region of the left side, where a crepitant rhonchus is heard; posteriorly tubal over a small portion of the lower lobe of the left side, and crepitant rhonchus throughout the same lobe most perceptible in the axillary region. Some nausea and vomiting; epigastrium tender to pressure. R. C. C. No. iv, over lower lobe of left side posteriorly. Half a grain of calomel also directed to be taken every two hours. The next morning found her considerably relieved, pulse fallen to 102, and of less volume, respiration 36, with less dyspnœa and fever. The nausea continues; bowels open five times. Physical signs as last night. Three cut cups applied to axillary region, and three grains of Pulv. Doveri added to the calomel on account of the diarrhœa.

August 7. General symptoms, pulse, &c., as yesterday. The respiration fallen to 28, with a corresponding change in the physical signs; the pneumonia seems now resolving itself; no dulness on percussion; the crepitant rhonchus changing into a submucous; same sibilant rhonchus heard on the right side; the diarrhœa continues; bowels open nine times since yesterday morning; stools thin, and passed without pain; complains of great nausea, vomited once yesterday; tongue thickly coated with a yellowish fur, red at the edges, papillæ elevated and injected; thirst very great; no appetite, no tenderness of abdomen on pressure; continue the calomel and Dover's powders; gum water for diet; fomentations to the abdomen.

Evening.—We were called in haste to our patient at 5 o'clock, this afternoon, on account of a great increase in the diarrhœa, which had become a violent dysentery; we found that she had been constantly on the close stool since two o'clock, complaining of severe and constant cutting pains throughout abdo-

men and especially over the region of the colon; tenesmus constant and urgent; could not detect any especial tenderness of the belly, "it was all sore;" no tympanitis; icterus (she is in about the fifth month of pregnancy) contracted into a hard mass; stools of a brownish yellow colour, offensive, thin and serous, no blood in them; when in bed lies with the limbs drawn up, and its constantly moaning; ordered forty leeches to be applied over the course of the colon, and followed by a warm flax-seed poultice with a tea spoonful of laudanum in it; gave also an injection of aq. opii. f3ii. in an ounce of mucilage, to be repeated in an hour.

At 9, P. M. found her lying quite easy with only an occasional pain. Bowels open only twice since 6 o'clock; injection to be repeated after every stool.

August 8. Bowels open five times since last visit; has had no pain since midnight, and no pain now on pressure over abdomen; no nausea; thirst great; skin warm and moist; pulse 110; respiration 28; percussion clear throughout the chest; very little submucous in lungs; same sibilant and sonorous rhonchus in both lungs; cough without expectoration; an infusion of ipecacuanha directed, and warm fomentations over abdomen.

From this time to the date of full convalescence, August 13th, we had to treat principally the diarrhœa, which yielded to the oleaginous mixture. The infusion of ipecacuanha was continued as a diaphoretic and expectorant.

On the evenings of the 9th, 10th and 11th, she had an exacerbation of fever without any local symptoms to account for it; a grain of sulphate of quinia was given every two hours during the 12th, and stopped it.

Remarks.

This was an admirable case to demonstrate the conversion of pneumonia into bronchitis, and then a return to health. It is doubtful how much was due to the treatment for this change, and how much to the diarrhœa and dysentery; I am inclined to attribute the result, however, to the latter cause.

Another point of interest was the entire absence of expectoration, either during the disease or the convalescence; the cough which she complained of was not at all harrassing.

The effect of the leeches in relieving the acute cutting pains of the dysentery was most happy; in three hours after their application, she was able to lie comfortably in bed, having been the three previous hours scarcely at all in bed, owing to the severity of the pain and the tenesmus. The danger of abortion was great at this time, and required energetic treatment. Fears were entertained that the opium given in the injections, and put upon the poultices, might have a bad influence on the bronchitis, but this it appeared not to do. The strength of the aq. opii was 3i to the pint, and two and a half fluid ounces if it were given altogether, equal to ten grains of opium, if the water had extracted its full virtues, which it probably did not; of this two fluid ounces, or eight grains were given during the first fourteen hours.

CASE II.

FEVER—EXTENSIVE BRONCHITIS, WITH ABSENCE OF ALL RATIONAL SIGNS. INTESTINAL HEMORRHAGY—RECOVERY.

C. S., Irish, aged 23 years, labourer, entered the hospital the evening of September 28th, with general febrile symptoms.

Detailed note, Sept. 29th. No satisfactory account

can be obtained from him, respecting his sickness, further than it came on three weeks ago, without a chill, but with fever and general illness, severe enough to confine him at once to his bed; he had been at work before this on a coal wharf.

With the exception of a good deal of muttering during his sleep he rested pretty well last night. The expression of his face this morning is dull, and is somewhat flushed; he is easily roused, but answers questions hesitatingly; is much inclined to sleep, has no heat of head nor headache; complains of dizziness and a buzzing in his ears; sense of hearing good; tongue moist with a yellowish fur; a viscid secretion about the mouth and lips; abdomen flat tympanitic, which tympanitis extends to the precordial region, obliterating the natural dulness of percussion observable there, as also the impulsion of the heart; both sounds of this organ can be heard; however; bowels not open since his entrance, tenderness on percussion below the liver; none of the rose-coloured papulae of typhoid fever observable on the abdomen; pulse 88, regular, and of moderate strength; skin moist; respiration 36, easy and regular, no expression of dyspnoea, no dilatation of nostrils, no cough, no expectoration, no pain; percussion of chest clear anteriorly, quite dull posteriorly over lower lobes; sonorous and sibilant rhonchi heard in both lungs anteriorly and very abundantly; posteriorly these sounds are heard principally in the right lung, mixed with a fine sub-mucous rhonchus, approaching to the crepitant; but little of them in the left lung posteriorly; a distinct fremitus felt on touching any part of the chest; decubitus dorsal. *R.* Six cut cups were applied to the right side posteriorly; a powder of rhubarb and soda given to open the bowels, and a table spoonful of the neutral mixture every two hours. Felt much relieved at evening; pulse 92; respiration 28; the sonorous and sibilant rhonchi much less abundant; bowels opened once; *R.* Four cut cups to axillary right side.

Sept. 30th. Remained in much the same state as yesterday; had a profuse sweat at 7 o'clock this morning, since which his tongue has become dry; pulse rose during the day to 120. *R.* Venesection $\text{f}\text{3iv}$; *R.* Hydr. c. mit. gr. xii; Kerme's mineral gr. j; Potass nit. 3ss . m. in chart No. vi. divided; one to be given every four hours.

Oct. 1st. Improved to day; face less flushed; pulse 96, small, skin warmer than natural; no uneasiness of head, no muttering during sleep, as on the first night; had some sweating again at seven o'clock this morning; some subsultus; tongue moist; bowels open once since last night; respiration 36; no dyspnoea, cough or expectoration; the amount of the rhonchi in the lungs much less than before, especially in the left; otherwise the physical signs remain as heretofore; continue the powders and give also the neutral mixture every four hours.

Oct. 2d. The general improvement continues; skin hotter than before; no sweating this morning.

Oct. 3d. Much the same; was somewhat delirious last night; tongue dry again; mouth not yet sore.

Oct. 4th. Not as well; tongue remains dry, is swollen; a dark coloured, and very viscid secretion, adheres to the lips and teeth; pulse 100; skin continues hot; when asked how he does, always gives the same answer of "first rate;" still inclined to sleep; breathing heavy and laborious; stupid expression of face; no delirium last night; more rhonchi in the lungs; percussion as before; coughed two or three times this morning for the first time; no expectoration; bowels rather freely open. *R.* Emp. Canth. $\text{vi}\times\text{vi}$. to right side, kept on six hours, and then ap-

plied to the left side, P. M. Both blisters have drawn well, but without producing any very evident amelioration of the symptoms; he has now taken about a drachm of calomel in divided doses, and yet no signs of ptyalism.

Oct. 5th. The obstinacy of the bronchitis, with the observation of the case so far suggesting the opinion that it was secondary to a fever, possibly remittent; it was determined to day, to give the sulphate of quinia freely, commencing early in the morning, as there had been at this time on two days at least, an evident remission; he was this morning, before taking this remedy, in much the condition of yesterday; pulse 100; skin dry, and harsh, but not hot; face rather pale, tongue dry, swollen, sordes about the lips and teeth; expression stupid, physical signs as before. Two grains of the sulphate of quinia were given in solution, every hour; at three o'clock, P. M. his pulse had gone up to 120; skin warm; had taken thus far sixteen grains; take two grains at five o'clock and again at seven o'clock, and stop, which made a scruple in all to-day.

Oct. 6th. Has a much better expression of face, there being but little stupor observable; tongue moist and cleaning; bowels open but once during the night; the stool being thin and brownish; pulse 108, soft; skin keeps dry; no cough, nor expectoration; some sonorous rhonchus heard in both lungs, the most in the upper lobe of the right lung anteriorly; considerable sub-mucous in the lower lobe of right lung posteriorly, almost amounting to a crepitus; percussion dull posteriorly; took but three doses (six grains) of the sulphate of quinia to day; during the rest of the time took neutral mixture; at bed time had his body sponged off with tepid vinegar and water, and gave him a foot bath.

Oct. 7th. Does not appear to be as well as yesterday, tongue a little dry again in the centre; still a tendency to sleep; continue the sulphate of quinia every four hours.

Oct. 11th. Remained in much the same state as before, and under the use of sulphate of quinia, and the neutral mixture; tongue remains moist; last night, the pulse rose from 108 to 118; had a copious stool this morning, with large clots of blood; Hope's nitric acid mixture, without the laudanum, ordered; other medicines discontinued.

Oct. 12th. Much the same; pulse up to 132, less full; give the sulphate of quinia again; arrow-root and beef tea, with wine for diet.

Oct. 13th. The stools became more natural yesterday; tongue much improved; pulse weaker, 130; the rhonchi not materially changed; three grains of the carb. ammoniac, directed every two hours alternately with the sulphate of quinia; the nitric acid stopped.

Oct. 17th. Continues dull, has had delirium every night lately, gets out of bed; subsultus; had to day a slight epistaxis; respiration 36, puerile anteriorly; sub-mucous rhonchus posteriorly in both lungs, abundant in the right lung, less of it in the left; dulness of percussion posteriorly over lower lobes of both sides; bowels open once this morning, and twice in the night in the bed; stools thin, and yellowish, pulse 128, and of moderate strength; a bad sore forming on the sacrum.

Take the nitric acid mixture as before; wine $\text{f}\text{3iv}$. a day; other medicines discontinued.

Oct. 18th. Intelligence better; begins for the first time to lie on the side on account of the sore, his decubitus having been heretofore invariably on his back; pulse 120; has a moderate diarrhoea.

Oct. 20th. Remains much the same, complains

more; cough insignificant; tongue moist, not furred; pulse 120; skin dry; eat some chicken yesterday, with a great relish; has a little delirium every night, passed his stools in bed last night. R. Ammon mur. ʒii , spts. etheris nit. fʒss . aquæ q. s. fʒvi , s. fʒss . qh. 3. R. Pil Hydrarg. gr. v, at night, followed by fʒii , of oil.

Oct. 23d. Diarrhœa better, stools healthier, bowels open three times, in the last twenty four hours. Tongue moist; pallid; pulse 112, moderately full; respiration 32; less rhonchi in chest than at last note; still delirious every night; continues to lie on the side; appetite excellent; complains greatly of pains in his legs; continue the ammonia and nitre.

Oct. 24th. A blister applied to the nucha, for the delirium.

Oct. 26th. Delirium lessened and feels quite well; no rhonchi to be heard in the chest; absence of respiration in the lower lobe of the right lung; vesicular throughout the left lung; pains in the legs continue quite severe. The notes were here discontinued, as the patient was entering upon a decided convalescence; the little diarrhœa soon stopped, and the action of the stomach and bowels, became in every way healthy by the first of November; all medicines were soon discontinued, and a good diet directed; nevertheless, the man remained weak, and it was sometime before he had strength to leave his bed; after this he improved more rapidly.

Remarks.

This case was an exceedingly interesting one, in the first place, on account of the entire suppression of any general symptoms indicating inflammation of the lungs, if we except one symptom, the frequency of respiration. He had neither pain, nor dyspnœa, nor cough nor expectoration. The occasional cough was more referable to the condition of the mouth and throat, than to that of the lungs. There was no expectoration during his sickness, although during the greater part of the time, there existed an abundant sub-mucous rhonchus. It will be seen that this is very like the first case reported, where the same condition of things existed. Such cases are occasionally met with and are exceptions to the general rule, that bronchitis relieves itself by expectoration. I cannot say that these cases were in any way prolonged on this account.

This was an interesting case, in the second place on account of the complication of extensive bronchitis with a fever. He had been sick three weeks, and was brought in probably about the time of the supervention of the bronchitis. This was treated exclusively for the first few days, the idea of the complication not suggesting itself. As soon as the bronchitis yielded a little, the sulphate of quinia, was given freely for one day, in the hopes of producing a decided result, while these effects were closely watched. The raising of the pulse, which followed, was not well marked until 3 P. M., the first dose having been given at 3 A. M. The man's improvement the next day was perceptible, especially in the clearing of the tongue and in the cerebral symptoms.

Was the fever typhoid or remittent? This is a question about which there must remain considerable doubt, and is the most important point connected with the case. The season of the year, the remission he had on two or three successive mornings, would favour the idea that it was remittent fever; while the early and continued dulness of the mind, and other cerebral symptoms, the epistaxis towards the close of the disease, the diarrhœa, and discharges of blood from the bowels, and even the bronchitis itself, be-

longed rather to typhoid fever. The effects of the sulphate of quinia would also encourage this conclusion; for the improvement in the fever was not positive enough for remittent fever. The abdomen remained flat throughout his illness, although there was some tympanitis, and without tenderness, except at first, over the liver. There were no sudamina, nor the papular eruption of typhoid fever.

The case next reported occurred at the same time, in the women's medical wards, and gave the same difficulty in diagnosis.

CASE III.

TYPHOID FEVER—UTERINE HEMORRHAGE—DEATH—AUTOPSY—REMARKS.

F. M., a German, aged forty years, entered the medical wards Sept. 24. I saw her that afternoon with Dr. Cary, whose patient she was. She could not speak English, and besides, was too dull to give any satisfactory account of herself. We could only learn that she had had a child about six weeks before, was intemperate, and had been exposed to the weather of late. She complained of being sick all over. Pulse 120, small, and rather hard; skin dry and warm; face flushed, and had a dull, heavy, livid tint; expression of face and eyes stupid, unless roused, when her eyes would assume a much brighter and more natural expression; has some subsultus; lies with her mouth partly open; tongue dry and brown, not furred, somewhat glazed; bowels open once a-day; belly slightly tympanitic and swollen, and quite tender on very moderate pressure; the femoral veins tender also, but not swollen; could not detect any enlargement of the liver or spleen; no vomiting; no typhoid papulæ or sudamina. Respiration natural; no cough or uneasiness of the chest. On examination, per vaginam, the os uteri was found quite dilated, and rather tender on pressure. The right heart sore and swollen. Small doses of blue pill, and the neutral mixture directed.

25. In much the same state. Under the idea that it might be a case of low form of remittent fever, and there being no symptom forbidding it, a grain of the sulphate of quinia was given every hour. The blue pill continued.

26. There was something of a remission. The pulse fell to 108. No increase of the tympanitis; the tenderness of the abdomen continued, was general, but most marked in the iliac and hypogastric regions.

27. A tendency to diarrhœa, which was checked by an injection of fifteen drops of laudanum. Poul-tices to the abdomen.

28. Quite a tendency to prostration; bowels not open since the injection yesterday; no thoracic symptoms; fever subsiding; less flush of the face; expression dull; tint of face livid; tongue continues dry; moans out quite loud at intervals. Ordered wine.

29. Prostration continues; bowels not yet open; no more moaning; commenced flooding to-day; the discharge comes on at intervals with a gush, and is very free; other symptoms as yesterday. Directed some oil. The poul-tices to abdomen discontinued. R. Ammon. Carb. gr. v., q. h. 2.

30. Rallied some last night and this morning. The other symptoms no better.

Oct. 1. The stupor increased during yesterday; was with difficulty roused last night; this morning perfectly insensible and moribund. Died at 6, P. M.

Post-mortem forty hours after Death.

Lungs healthy. Liver not enlarged, but much softened, and red. Spleen of a dark blue colour, and somewhat enlarged—not notably softened. Mesenteric glands enlarged and softened. The sub-peritoneal coat of the intestines so softened that they could be stripped out from the peritoneum. Considerable injection of the mucous membranes of the intestines, both large and small, and in portions deeply and fine enough to constitute inflammation. This was particularly noticed at the head of the colon, and in different portions of the ilium, corresponding to a number (eight or ten) of enlarged, elevated, and injected patches of the glands of Payer. The lowest of the patches was situated about two feet above the ileo-colic valve, and thence extended at intervals up to the central and upper portions of the ilium. These patches were in no instance ulcerated.

Remarks.

This was an undoubted case of typhoid fever, and in many respects it resembled the case of C. S., especially in the non-appearance of the external symptoms so generally looked upon as diagnostic. In neither case did the cerebral symptoms appear grave enough at first to say positively that it was typhoid fever, when taken in connection with the absence of the cutaneous eruption, and the slight abdominal symptoms existing. No absolute diagnosis between remittent and typhoid fever could be made, therefore, at the commencement in either case; and it became a mere calculation of probabilities, in the decision, as to which it was.

In the man's case, the discharge of blood from the bowels, the epistaxis, the increase of the delirium, his attempts to leave his bed at night, the diarrhoea and involuntary stools together, served to clear up the diagnosis, and to render it quite positive. The pains in the legs were quite severe, more so than ordinary in those cases of convalescence from typhoid fever in which they are met with.

The points worthy of observation in the woman's case are, *first*, her age, forty years, greatly above the average age in which we meet with this fever; *second*, the great tenderness of the abdomen; *third*, the occurrence of uterine hemorrhage two days before death; and *fourth*, as already mentioned, the absence of the typhoid or cutaneous eruption.

BIBLIOGRAPHICAL NOTICES.

A Practical Treatise on the Diseases of Children. By D. FRANCIS CONNIE, M. D., etc. etc. Philadelphia: Lea & Blanchard. 1844. 8vo. pp. 651.

The object of the author in the present treatise is, "to present a full and connected view of the actual state of the pathology and therapeutics" of the diseases which occur between birth and puberty. The pathology of infantile affections has been of late years much extended and elucidated, and simpler and more certain therapeutics have been the consequence. The older works on this subject are, therefore, deficient in many points of importance, and are very imperfect guides for the student. The foreign treatises, many of which are excellent, are defective, so far as regards the forms of disease peculiar to our climate. A practical work on the Diseases of Children was, therefore, much needed in this country, and the

present one is intended to fulfil this indication. Let us see how successfully this has been done.

Whilst the author has liberally and judiciously appropriated the labours and opinions of others, this has generally been done when their views were confirmed by his own observation and experience, which have been "acquired during a long and somewhat extensive practice, and under circumstances peculiarly well adapted for the clinical study of the diseases of early life." In a few instances only, where the authority was high and unquestionable, has this rule been deviated from. On those points where decided difference of opinion prevails in the profession, our author has adopted those views which coincided with the results of his own observation, giving, at the same time, when the importance of the subject demanded it, "a fair exposition of the views of others in relation to it."

The work is divided into two parts; the first treats of infantile hygienics and general pathology, and the second is devoted to special pathology, both internal and external.

The nature of the work necessarily precludes any extended critical or analytical notice. The author is evidently a man of considerable practical familiarity with his subject, and at the same time a laborious student; two essential requisites in a writer. He has apparently thought much and well on the various points he treats of. His pathological views generally please us; with extensive knowledge, there is much judgment and reflection. The same may be said of his therapeutics. The character of the work is far above that of a summary of the actual condition of infantile pathology. It is an excellent *Practical Treatise on the Diseases of Children*, and a very safe guide to the juvenile practitioner and student. The limited space necessarily precluded much detail; but our author's style is condensed, and the retrenchments have been made commonly at the expense of the theoretical portions of the work. We welcome its appearance, and have no doubt that it will assume and maintain its rank amongst our standard medical books. With this opinion we will venture the following critical remarks.

The pretensions of the work, however justly, are rather too warmly stated in the Preface, on the score of taste. The old adage of "good wine needing no bush," is applicable in the present instance. An author, aware of the difficulties he has encountered, full of his subject, and frequently feeling his superiority, is disposed to make the public a participator in his feelings; but this is rarely reciprocal, the latter being cool and unsympathizing. We do not understand on what just pathological grounds Jaundice and Cyanosis are ranked among skin-diseases. The exploded orthography of scrofula (scrophula) is disinterred, with what view we cannot comprehend, the derivation being from *scrofa*; and nutritious is spelt *nutricious*, on what authority we are at a loss to say. At p. 144 we notice that "a few grains of aqua camphorata or spirits of turpentine" are ordered. The numerous references in the body of the page are, we think, disfiguring and unnecessary; many might be omitted with advantage, and the remainder incorporated with the text. These may be unimportant matters, but we are unwilling to see any blemishes upon so excellent and timely a work.

A Treatise on Dislocations and Fractures of the Joints.

By Sir ASTLEY COOPER, Bart. F. R. S., etc. *A new Edition, much enlarged.* Edited by BRANSBY B. COOPER, F. R. S., Surgeon to Guy's Hospital. *With additional Observations, and a Memoir of the Author.* Philadelphia; Lea & Blanchard. 1844. 8vo. pp. 499.

A mere announcement of a new edition of this great work would be sufficient were it a mere reprint from the former one; but we are told by Mr. Bransby Cooper, in the Preface, that "the very grateful task of Editor" was assigned him by his uncle some time previous to his death, and that the present edition embodies much new matter, left by Sir Astley himself, together with additional cases, derived from the practice of the editor, and various other sources. Some condensation has been made in the original; this is generally slight and insignificant, although once or twice it leads to false inferences and mistakes. The work is a splendid monument to the genius of the author, and stands unrivalled as a monograph on the subject, but it is still the record of the opinions and practice of an individual, most distinguished it is true, but of an original and practical turn of mind, and not very erudite in the literature of the profession, who chose rather to state what he saw and knew, than to record the views of others. As Mr. B. Cooper undertook the duty of editor, he should have fulfilled it, and contrasted the opinions of Sir Astley Cooper with that of other distinguished surgeons of the day, "either to the confirmation or the condemnation of the views laid down by Sir Astley Cooper in the treatment of fractures and dislocations of the joints;" he should have placed the work on a level with the existing state of knowledge on the subject, and this he has not done. His opportunities and information should have qualified him for the task, and if his literary abilities were deficient, his notes might have been committed to other hands. Although an inefficient editor, Mr. Cooper's additions and comments are often valuable and judicious, although many are unimportant, and his style is generally careless, and sometimes obscure. No one was better qualified to supply the faults of omission on the part of the English editor than the eminent individual who has superintended the republication in this country, and has added numerous valuable cases. We regret that Dr. Warren did not embrace this opportunity of giving us his experience on this class of injuries, linking his name with that of his illustrious preceptor. The additional observations that he has favoured us with are detailed in the full spirit of the original, and are interesting and instructive. We will notice one point to which he has called attention, we believe for the first time—the *unfrequency of dislocation of the os femoris in the female*. Dr. Warren states that in an experience of thirty-eight years, he has never seen an instance of dislocation of the os femoris in an adult female, and one only in a female under age, a girl of nine years of age. Curious to discover if the experience of other surgeons accorded with his own, he made numerous inquiries during his visit to Europe in 1837 and 1838, which were generally received with surprise, the question apparently not having before been adverted to. For some time he could not ascertain a well authenticated case, until Mr. Clift, the Conservator of the Museum of the Royal College of Surgeons, London, mentioned one to him—a case of double

dislocation, into the foramina ovalia, which was never reduced. Subsequently he heard of a few cases, especially from Dr. Stevens of New York, who stated that he had seen two or three. Sir Astley Cooper mentions above fifty cases of dislocation in the male, and but one in an adult female, and one in a female under age. This accident must necessarily be exceedingly rare in the female, fracture of the neck of the femur, being frequent with them, and rare in the male. Can the accident peculiar to each be explained by any difference in the anatomical structure of the two sexes. Nine measurements of the circumference of the neck of the thigh bone in the male and female, showed "that the cervix of the os femoris in the female is less in circumference, by at least half an inch, than the same part in the male. This being the fact, a force applied to the femoris would be much more likely to produce fracture of the cervix in the female than in the male, and the comparative frequency of dislocation in the female would be necessarily diminished. Another fact which explains the more frequent occurrence of fractures of the cervix in the female, is, that the greater breadth of the pelvis in them produces a corresponding projection of the trochanter, which of course renders it more obnoxious to external violence," (p. 98.)

At p. 14 Sir Astley Cooper says, "I have read of dislocations of the hip in children, but their history is that of diseases of the hip joint, in which the dislocation has arisen from ulceration." A case is subsequently given, (p. 391, of dislocation of the femur on the dorsum illi,) in a child seven years old, not seen by Sir Astley, but communicated to him by Mr. Daniell, a dresser in the hospital. Dr. Warren alludes to one incidentally in the paragraph quoted above, occurring in a female child nine years old. Should not Dr. Norris's case in a boy eleven years old have been mentioned, together with a few other authenticated cases on record, of dislocation of the femur in childhood?

The present edition is handsomely printed, and is illustrated with a beautiful engraving of the author. The wood cuts are indifferent.

FOREIGN CORRESPONDENCE.

The School of Medicine—Dr. Royer-Collard and his Address—Scene between the Orator and Dr. Piorry—M. Guérin and his Procès—Protest of the Parisian and Provincial Physicians against his Conduct—Hydrophobia and M. Baudens—Dr. Martin-Solon's Treatment of Rheumatism with large doses of Nitrate of Potash—Dr. Trousseau on Paracentesis Thoracis in Acute Pleurisy—Dr. Ricord's Accident—Syphilitic Inoculation—Dr. Segalas—Carbonate of Lime Calculi—Sea Sickness due to Fear—Effects of Tobacco on Consumption—Appointment of M. Maligne—Successful Treatment of Puerperal Convulsions by Hemospasy—Gerdy's Experiments on Reduction of Luxation of the Shoulder.

To the Editor of the Medical Examiner.

PARIS, 8th November, 1843.

SIR,—On Friday last (Nov. 3d) the School of Medicine opened, with an inaugural address by Dr. Royer-

Collard, the Professor of Legal Medicine. His subject was the necessity of the physical and chemical sciences in medicine. The style was chaste, correct, and sometimes even *spirituel*, and the manner lively and pleasing, but there was nothing new or striking. In the course of the address several caustic remarks were made by the orator on his confrère, Dr. Piorry, and his bizarre nomenclature; and the orator of last year, Dr. Trousseau, was also handled rather severely. On the retirement of the Faculty to their apartment, a scene is reported to have occurred between the orator and the injured professor, which was adjusted after some difficulty, it being understood that the Professor of Internal Pathology should be the next annual orator, and in that way revenge himself. The unity of instruction in the School was much insisted on by Dr. Royer-Collard. Facts are too stubborn for even the eloquence of the Professor to overcome.

M. GUÉRIN's suits have not yet come up at the Salle des Pas-Perdus. The severe laws against the Press, for political purposes, may, it is feared, turn the issue most unjustly in the present case. Guérin has lost all standing with the profession, which is unanimous against him, as you will see by the journals. The provincial physicians are also daily sending in their signatures to the protest of the medical body here against his conduct.

BAUDENS, Surgeon to the Duke de Nemours, and chief professor at the Military Hospital of Val de Grace, is treating his rheumatic patients with hydropathy, and, he says, successfully. He has published a case of chronic arthritis with ankylosis of most of the principal joints and endocarditis, speedily and entirely cured by this method.

Dr. MARTIN-SOLON read an elaborate memoir at the Academy of Medicine the other day, on the Treatment of Rheumatism by large doses of Nitrate of Potash. According to him, it is easily tolerated by rheumatic patients in doses of from twenty to sixty grammes. It is more successful in mono-articular rheumatism than in poly-articular—often arresting the disease at once, and generally curing it in from three to seven days. If no benefit is derived from it within three days it should be discontinued, and another plan of treatment substituted.

PROFESSOR TROUSSEAU read recently a memoir on Paracentesis Thoracis in acute pleurisy, where the abundant effusion threatens the life of the patient. He first attempted to demonstrate the harmlessness of wounds of the chest, where the great vessels are not involved, and to prove also that the introduction of air into the cavity of the healthy pleura was unattended with great danger; and that even when inflammation of the serous membrane existed, if the quantity of air is not great, and the introduction frequent, that but little danger was to be anticipated. He combated the opinion of Dr. Louis, that simple pleurisy is always easily cured, cited several cases in support of its gravity, stating that he believed death to be due in such cases rather to the effusion than immediately to the inflammation. He mentioned the case of a young girl, in whom, in September last, he performed on the ninth day, when the symptoms of suffocation became imminent, paracentesis, with the instrument ordinarily employed in hydrocele. More than a quart of fluid was withdrawn, the wound closed, and the patient

recovered. As to the mode of operation, he declared himself a partisan of that by repeated evacuations.

Dr. RICHARD, in dressing a chancre some days since, wounded the thumb of his left hand with the scissors. Phlegmonous inflammation followed, and the wound assumed a bad aspect. In order to satisfy his doubts as to the real nature of the wound, he inoculated his left fore-arm with some of the pus. At the end of twenty-four hours a characteristic pustule appeared, which he cauterised with the Vienna Paste. No doubt of the existence of the local infection remained. The original wound became indurated; the cauterised chancre did not. He submitted himself to an antisyphilitic treatment. In the verbal communication which he made to the Academy on the subject, he stated that he wished to practise on himself inoculation, to show, first, how sincere were his convictions on this point, and secondly, to prove that the assertion that he practised inoculation on others from mere curiosity was false, and that he believed it to be a pure question of science and art, resolved in the most satisfactory manner.

Dr. SEGALAS stated that he had never seen calculi of carbonate of lime, unless the patients had previously taken carbonate of soda. Dr. Leroy d'Etiolles considered the law, as given by Dr. S., as too absolute; he believed that the occurrence of carbonate of lime in calculi was rare, where the alkaline carbonates had not been used. Dr. Caventou inquired of Dr. Segalas whether he had ever seen calculi of the carbonate of lime which did not contain phosphate of lime. Dr. S. answered, that in the few cases that he had met with of calculi of the carbonate of lime the phosphate of the same base was present.

Dr. GUERPRAT, a French naval surgeon at Brest, believes that sea-sickness is always due to fear. The commission appointed to inquire into his memoir, combated and denied this novel doctrine.

In a recent report on the health of the workmen in the tobacco manufactories in France, by M. SIMEON, the director-general of the administration, it is stated that phthisis is exceedingly rare, comparatively, among them. This fact is attested by the physicians of the manufactories at Bordeaux, Havre, Lille, Morlaix and Strasbourg.

M. MALGAIGNE has been appointed surgeon to the hospital of St. Antoine, situated in the Faubourg of that name.

Dr. CAZEAUX has published two cases of puerperal convulsions successfully treated by Hemospasy,* (*les ventouses Junot.*) They were applied upon the leg and thigh several times in the course of the twenty-four hours.

M. GERDY has lately made some interesting experiments to determine the lesions which may arise from undue efforts in reducing luxations of the shoulder-joint. In May last a patient entered the surgical wards of La Charité with dislocation of the head of the humerus downwards and forwards, of three weeks duration. Three attempts at reduction were made on the morning of the 5th, ineffectually. On the 7th two other efforts were made; the first failed, and during the second, M. Gerdy remarked on the inner face of the arm a cord firmly stretched, which he supposed to be the median

* See Medical Examiner, No. 20, p. 240.

nerve. The patient complained very much, and M. G., fearing the rupture of the nerve, intermitted any further exertions for the time. The following day he made several experiments on the dead body, with the view of ascertaining, 1st, the influence of violent efforts of extension on the various tissues of the limb, as the nerves, muscles, vessels and ligaments; 2d, the influence of extension, where the fore-arm is extended, and where it is flexed. The result was, that forcible extension is capable of rupturing the muscles, but that they do not become tense as soon as the nerves, where the forearm is extended at a right angle with the trunk; that the nerves thus stretched are, first, the median, then the internal cutaneous, then the cubital and radial; that the brachial vessels are less stretched than the nerves; that if the extension be carried too far, the median and internal cutaneous are ruptured. The facility with which the tense nerve or nerves may be recognised beneath the skin, readily announces the danger. These experiments also proved, that when the fore-arm is flexed on the extended arm the muscles become equally involved with the nerves; that they are stretched together, resist together, and are ruptured together.

DR. CRAIGIE ON THE PATHOLOGICAL CAUSES OF CYANOSIS.

It has been usually supposed that the open state of the *foramen ovale*, whether direct or oblique, is a primary lesion of the heart, and is pernicious to the patient, in allowing the free intermixture of the blood of the right chambers of the heart with that of the left. Within certain limits this idea is well-founded; and in a certain number of cases, the open state of the *foramen ovale* tends to impede nutrition and to abridge the duration of life. I am, nevertheless, satisfied, both from the facts of the case now related, and several others, of three circumstances; first, that the open state of the *foramen ovale* is rarely a primary and solitary lesion; secondly, that when it is a solitary lesion it is not injurious, and the venous blood of the right auricle is not thereby necessarily mixed with the arterial blood of the left auricle; and thirdly, that, in opposition to what has been hitherto usually taught, the open state of the *foramen ovale* is in a large proportion of cases the means of prolonging life.

It is unnecessary for me to enter into any formal defence of the latter conclusion, which, however paradoxical it may seem, and however opposed to the usually received dogmas, flows almost directly from the facts which may be traced in every case of open *foramen ovale*. That, in short, is not the primary lesion. From the phenomena of the cases recorded, on the contrary, and from the frequency of the arcuated or contracted state of the pulmonary artery, it must be inferred that the obstructed state of that artery is the primary lesion, and determines not only the open state of the *foramen ovale*, but the hypertrophy of the right ventricle. This is the result, whether the pulmonary artery is only greatly narrowed in calibre, or terminates in a *cul de sac*, or is obstructed by a membranous partition formed by a coalition of the semilunar valves.

The effect of such an impediment is manifest. The blood cannot pass into the pulmonary artery with the requisite freedom and facility. The result is over-distension, first of the right ventricle, and excessive labour of its muscular apparatus; secondly, of the right auricle, and excessive labour of its muscular

apparatus, with extreme dilatation of its membranous portion; thirdly, over-distension and congestion of the whole venous system all over the body. The lungs, meanwhile, receive little or no blood, and, consequently, the blood is not duly aerated or supplied with oxygen, and cleared of carbon and carbonic acid. This is doubtless an evil and a great one. But Bichat has obscurely suggested, and Dr. Williams and Dr. Kay have clearly shown, that dark-coloured blood, or that which is venous, is adequate to maintain vital action. It is, indeed, a less evil, and more tolerable than total obstruction in any of the large vessels, and especially in a vessel like the pulmonary artery. Every thing that we now know of these cases shows that the obstruction to the circulation through the pulmonary artery must be the main cause of the short and transitory existence of persons labouring under this severe lesion; and that the open state of the *foramen ovale*, instead of being as William Hunter and other authors imagined, a cause of death, furnishes the only means by which life can be prolonged, while a function so important as that of the circulation through the lungs is impeded.

I am further entitled to infer from various facts in the history of the development of the ovum, that the obstructed, or, it may be, the undeveloped state of the pulmonary artery, is the anatomical cause of the perforated septum, and of the origin of the aorta from the two ventricles when that malformation is observed.

It would lead to some curious and interesting results to inquire by what means the impeded function of the lungs is in these cases compensated; for that it is compensated by the action of the skin and other membranes, can scarcely be doubted. But this would lead me into a field too extensive for consideration at the present time.—*Edin. Med. and Sur. Jour.*, October 1, 1843.

STATE OF THE URINARY SECRETION IN CASES OF POISONING BY ARSENIC.

BY M. DELAFOND.

M. Delafond made a number of careful experiments on horses and dogs, to ascertain whether the urinary secretion was arrested during the poisonous action of arsenic, or continued to go on. After keeping the animals without food for some hours, he employed a particular apparatus to collect the whole urine which was passed in twenty-four hours; and after ascertaining this point he administered a poisonous dose of arsenic, and still keeping the animal starving, collected the urine. In every case he found that a notable quantity of urine continued to be secreted, even when the poison killed the animal within the hour; but that in most cases the quantity was less than what it was when the animal was healthy. In every case the urine was loaded with arsenic. These experiments were also repeated before a Commission of the Academy of Medicine, and found by them to be correct, as stated by Delafond. This, therefore, sets at rest the question which has been agitated between Orfila and MM. Flandin and Danger, as to whether the urinary secretion was suppressed in cases of acute poisoning by arsenic. Orfila maintaining that it was not, and MM. Flandin and Danger that it was.—*Edinburgh Medical and Sur. Journal*, October 1, 1843, from *Bulletin de l'Académie royale de Médecine*.